STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT REHABILITATION CENTER, LLC	3518 SOUTH LAFOUNTAIN STREET KOKOMO, IN46902

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F0000	This visit was for the Investigation of Complaint IN00095480. Complaint IN00095480 - Substantiated. Federal/State deficiencies related to the allegation are cited at F-223, F-225 and F-226. Survey date: August 25, 2011 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Survey team: DeAnn Mankell, RN Census bed type: SNF: 8 SNF/NF: 45 Total: 53 Census payor type: Medicare: 8 Medicaid: 36 Other: 9 Total: 53 Sample: 6 Supplemental sample: 2 These deficiencies also reflect state	F0000	By submitting the enclosed information we are not admitting the truth or accuracy of any specific finding or allegations. We reserve the right to contest the findings or allegations as part os any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of complianec to the state findings of the complaint conducted on August 25, 2011.Tha facility is requesting a DESK REVIEW.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings cited in accordance with 410 IAC 16.2. Quality review 8/31/11 by Suzanne Williams, RN			
F0223 SS=G	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, observation and interview, the facility failed to prevent resident to resident sexual abuse for 1 of 1 resident who had an allegation of sexual abuse (Resident B). This practice resulted in Resident B becoming upset to the point of having tears in her eyes when she recounted the incident of the sexual abuse by another resident (A). The facility also failed to ensure resident to resident physical abuse and staff to resident verbal and physical abuse were prevented. This deficient practice affected 5 of 5 residents who had allegations of abuse in a sample of 6 (Residents B, C, D, E, and F). Findings included: 1. During the facility tour with the house supervisor, on 6/25/2011 at 10:10 A.M., Resident B was identified as having made an allegation of abuse toward Resident A.	F0223	Corrective Action: 1. Resident's B,A, C ,D , E and F was assessed and has not had any ill effectes related to the alleged allegation. 2. Resident A was placed on 15 miniute checks. resident was also seen by psychiatrist services on 8/19/11 and then placed on 1-1 on 8/22/11 until his transfer to Generations Behavioral unit on 8/23/2011. In the event that any further allegations occur they are to be reported immediatley to the Administrator or a designee of administration in the absence of the Administrator. The administrtor or administrative designee will immediatley report the allegation to the Indiana State Department of Health utilizing the Unusual Rporting guidelines in accordance with facility policy. Identification: Any allegation of abuse will be immediately to administration who will immediately notify the Indiana State Department of Health in accoordance with the reportable guidelines. Any	08/26/2011

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	Resident B's clinical record was reviewed on 6/25/2011 at 2:35 P.M. Resident B's diagnoses included, but were not limited to, hypertension, diabetes mellitus, hypothyroidism, urine retention, and diarrhea. Resident B's admission MDS (minimum data set) assessment dated 6/20/2011 indicated a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating she was alert, oriented, and able to make independent decisions. Resident B's progress notes indicated on 8/21/11 at 3:00 P.M., "Res. (resident) c/o (complained of) being assaulted by another resident. Nurse mgr. (manager), social srvs. (social services), and administrator notified of incident." The facility conducted an investigation into the allegation with the following information in the investigation file. LPN #1 had filed an "Accident/Incident Report" with the following information: "Date of incident 8-19-11. Time of incident, 4 P.M. Location incident occurred, Hallway Resident in wheelchair. Unobserved Physical assault/Altercation. Describe exactly what you observed or heard: Resident wrote a complaint stating another resident 'grabbed' her		employee who fails to follow facility policy on reporting of Unusual Occurrences will be subject to discipline up to and including termination.System Change: A mandatory inservice was provided for facility staff on the Abuse Policy. The staff was educated that failure to follow facility abuse policy will result in disciplinary actions up to and including termination of employment. In addition the facility has implemented a process change for reporting mental health changes as noted in the progress notes from the provider of services. The professional conducting any treatment or revision of treatment plan will conduct an exit interview with the Social Service Director and discuss any changes in relation to that residents plan of care. Also, a log willl be maintatined indicating who has been seen for services. If changes are noted, the form will be initialed off by SSD and will also be forwarded to the respective Charge nurse to review and then forwarded to the DON for review and filing in the clinical record.Monitoring: Following any allegation of alleged abuse the IDT will meet and review the findings. The team will validate that all components of the abuse policy have been followed and appropriate follow up has been initiated. The IDT team will review	

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	inappropriately and came into her room and unzipped his pants while she was in bed." LPN #1 had written a statement dated 8/21/11 at 2:30 P.M. indicating "I was called in to (Resident B's) room. (Resident B) informed me that she was 'grabbed' inappropriately at her 'private parts.' Told her that she would need to write up the incident as it happened and that the nurse mgr (manager), social services, physician, and the center administrator would have to be notified." Resident B's hand written note indicated "Aug 21, 2011 2:30 p.m. This is to let you know that (name of Resident A), on the nineteen (sic) of aug. (August) at about 4:00 pm (sic) across from the Nurse (sic) station He (sic) reach (sic) over & touch me on the brests (sic). Then he touch (sic) my p. parts below. And it also happen (sic) once before in my room. I told him to stop quit, dont (sic) touch anymore & leave me alone. He does this allmost (sic) ever (sic) day. and i (sic) don't like it. So Im (sic) afide (sic) his (sic) (name of Resident G-Resident A's sister) won't like it becase (sic) I'm telling what been happing (sic). So I going to sit with (Resident H) from now on in the dinning (sic) room." There was a notation of "I wrote this for (name of Resident B).		all allegations during our daily stand up meeting conducted Monday thru Friday. Any continuing issues / or problems will be referred to our facility QAA committee for further recommendations and /or resolution. The QAA committee may discontinue any further monitoring once compliance has been acheived. ADDENDUN: YES , IT IS THE PRACTICE OF THE FACILITY TO INTERVIEW OTHER RESIDNETS WHO RESIDE N THE SAME AREA OF THE ALLEGATION THAT TOOK PLACE. WE WILL INTERVIEW a RANDOM SAMLING OF 4-6 RESIDNETS BASED ON THE ABILITY TO BE INTERVIEWED ACCORDING THE MDS. iF ANALLEGATION OCCURES INTERVIEWS WILL BE COMPLETED. Any reportable event will be reveiwed weekly for three weeks through our IDT process , monthly for three months through our monthly Clinical Complianc reviews, and then quarterly for three months utilizing our QAA process. Any continuing issues / and or problems will be brought to the QAA committee for the furhter recommendations and /or resolution .	

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	I think she need help with (sic). Thank you (Resident H)." There was an addition at the bottom of the note of "on the time he cane (sic) in my roon (sic), he also unzipped his pants and put his hand in them and I told him again he would have to leave because I had to go to the bathroom." Signed by Resident B. There was a written note by the SSD dated 08/21/2011 with the following information: "(Name of SSD) spoke with (Resident B) in her room ... her sister was present during this time.... (Resident B) stating 'on Friday afternoon, around 4 pm or so, I was sitting in the hallway by the nurses station, (Resident A) came and sat down beside me, since they were spraying his room. I noticed he was acting odd, that he kept looking at the nurses station, then down each hallway. He then reached over and grabbed by breast. I pushed his arm away, told him that I'm a resident here, I don't want him to do that, and I didn't want blood on my shirt since he had blood on his hands'. SSD asked 'Blood was on his hands?' '(Resident B) replied 'Yes, from where he picks behind his ear'. (Resident B) then states, 'I closed by eyes because my head was hurting. That's when he grabbed me between my legs. I pushed his hand away and told him he			

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	needs to quit. He then said 'I want some of that.' then he smacked his own hand and said 'Bad!'. I told him again that he ought not be doing that and pointed to (RN #1) coming down the hall, and said that he can't be doing things like that in a place like this.' SSD asked if anything else happened then, and she replied 'No, but is happened earlier too.' SSD asked 'When?'. (Resident B) then states; 'It was in the middle of the week, not sure what day. I was in my room because my stomach was upset and my head hurt bad. He came in my room and I told him that I didn't want to talk. He sat down in the chair next to my bed and said he just wanted to talk. I asked him where (name of Resident G) was, and he said she was asleep. He then reached over and grabbed my breast. I told him to stop. He then reached over and grabbed between my legs, and I told him to stop again. I turned on my call light because I wasn't feeling well. He then unzipped his pants and placed his hand down his pants. I told him he needs to stop that, that the nurse is on her way. He looked like he was made (sic), zipped up his pants, and left the room. SSD asked if these 2 times were the only times. She said 'Yes, but he will stand at my door and stare at me. That's why I close my door most times.'. She then stated, 'I don't want to get no one in trouble, but I don't like him doing that."			

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	The SSD had interviewed Resident A on 8/21/11 with the following written statement. "(Name of SSD) spoke with (name of Resident A) outside at the gazebo. SSD asked him if was in (Resident B's) room, he replied 'yes'. When asked what happened, he replied 'nothing'. Asked what night it was, and he replied 'Monday'. He then states 'Was just visiting. I've no problems with (name of Resident B).... SSD asked if he & (Resident B) are friends, and he replied 'yeah, yeah'. Then asked if they were more than friends, and he replies 'no, just friends'.... SSD asked if he visits with (Resident B), and he replies 'sometimes'. Asked if they ever kissed, and he replied 'no, no'. Asked if any thing like that goes on, and he replies 'oh, no'. SSD left (Resident A) sitting in the gazebo." The conclusion, written by the SSD on 8/22/11, was "The facts given by (Resident B) cannot be confirmed. (Resident A) confirmed they are friends, yet states they are only friends. (Resident B) is alert & oriented X 3. (Resident A) is currently on Q15 (every 15) mins (minute) checks due to incident involving a fellow neighbor occurred (sic) on 8/17/2011. (Resident A) has been referred for inpatient psy (sic) stay, and is awaiting transfer."			

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	Resident B was interviewed on 8/25/2011 at 3:30 P.M., she said essentially the same events that she had told the nurse and SSD on 8/21/2011. As she talked she had tears in her eyes which were slowly running down her cheeks. She indicated she didn't want anyone to be in trouble, but Resident A had hurt her feelings and she had told him to stop. She indicated she had been eating at the same table as Resident A and his sister Resident G, but she had asked to move to a different table after she had told the facility. During an interview with the DON on 8/25/2011 at 2:40 P.M., she indicated Resident A was placed on every 15 minutes checks after he had hit Resident D and then on 1 to 1 after Resident B's allegation of sexual abuse. She did not know how this incident could have occurred as the resident was on every 15 minute checks. The 15 minutes checks form was reviewed for 8/19/2011. The form indicated at 4:00 P.M., the resident was in Bingo and at 4:15 P.M., he was in the S. Hallway. Resident A was independently ambulatory. Resident A had been placed on one to one on 8/22/2011. The interdisciplinary progress notes indicated at 5:10 P.M. "...			

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	1-1 initiated @ this time...." Resident A was transferred to a behavioral unit on 8/23/2011. 2. Resident A's clinical record was reviewed on 8/25/2011 at 1:55 P.M. Resident A's diagnoses included, but were not limited to dementia, heart ischemia, COPD (chronic obstructive pulmonary disease), hypertension, and recurrent stroke. Resident A's Quarterly MDS (minimum data set) assessment dated 6/30/2011 indicated a BIMS (Brief Interview for Mental Status) score of 12/15 indicating he was moderately impaired cognitively. Resident A's interdisciplinary progress notes dated 8/17/2011 at 7:55 P.M. indicated "Res. heard entering building, writer seen Res (Resident A) propelling sister (Resident G) from lobby hallway towards Walnut nursing station, heard (name of Resident A) say 'why do you have that,' (Resident A) grabbed hoyer pad from res. (Resident D) lap-pulling (L) (left) hand towards (R) (Right) side et then swing open hand ([L] hand) back to (L) side et hit (Resident D) on (L) forehead, writer immediately separated residents et requested (Resident A) to ambulate to his room, paged supervisor immediately - had (Resident D) sitting c			

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	(with) writer...." Resident A's interdisciplinary progress note dated 8/18/2011 at 3:00 A.M. indicated "Res resting quietly in room. No (indicated by a circle with a line through it) behaviors noted this shift. 15 min checks (indicated the a check mark) initiated related to previously noted behavior...." Resident A was reassessed by the psychiatric services nurse practitioner on 8/19/2011 with notations of "Pt. hit another resident yesterday. Continues to be verbally aggressive, agitated, fixated on specific residents.... Continues to specifically mention 3 residents by name and remains unable to discuss or agree to nonviolent conflict resolution attempts. Pt. has hx and presentation suggestive of Vascular Dementia d/t (due to) CVAs (cerebral vascular accidents - strokes) and CKD Stage 4 (chronic kidney disease) with superimposed delirium. He remains aggressive, agitated and unable to track attempts to find non-violent ways to address his concern with 3 specific residents." The recommendations was "Immediate inpatient psych stabilization pending STAT labs + Depakote (anti-psychotic medication) 250 mg (milligrams) BID (2 times a day) if unable to transfer NOW."			

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Resident A was transferred to a behavioral unit on 8/23/2011 as the facility was unable to find an empty bed in all units contacted.

Resident D's clinical record was reviewed on 8/25/2011 at 2:53 P.M.
Resident D's diagnoses included, but were not limited to, Alzheimer's dementia, hypertension, anemia, and carotid stenosis.

Resident D's Admission MDS (minimum data set) assessment, dated 8/3/2011, indicated Resident D was unable to be interviewed and she was assessed as moderately impaired for decision making skills. She was assessed for wandering in the facility.

During an interview with LPN #4 on 8/25/2011 at 3:10 P.M., she indicated Resident D always wanders in the facility. She indicated Resident A had been pleasant before this incident. She was the nurse in the building when this had occurred and had seen what had happened and Resident A had said to Resident D "why do you have that?" referring to the hoyer pad she had with her in the wheelchair. She indicated the incident had happened so fast, she could not stop it.

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3. A "Grievance/Complaint Report" dated 4/30/11 was reviewed. Resident F had filled a complaint against a CNA who works at night.

The facility had investigated and had reported this to the ISDH on 5/2/2011.

The SSD had interviewed Resident F on 4/30/2011 with a written interview. Resident F had said "I got the girl mad... she said she's not going to take care of me anymore because of something I said. She then stated 'I'm 99 years old, I can't remember what I said. I tried to apologize, yet when she left she was so mad.' (Resident F) then stated 'I refused to take a shower. I used my walker today to walk to my bathroom.'"

RN #1 had interviewed Resident F on 4/30/2011 with Resident F saying "The girl was going to give me a shower in my w/c (wheelchair). I got the girl mad - she said she wasn't going to take care of me anymore. She said I said something. I tried to apologize - she was so mad. She wanted to give me a shower, but I didn't want a shower...."

CNA #1's written statement dated 4/30/2011 indicated,"At approximately 8:15 A.M. while in the Dining Rm.

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	(room), (Resident F) stated that 'the one with the stringy hair that works night said she is not going to take care of me anymore because of something I said.' ... reported this to the East Nurse who immediately went to call (the Administrator). The grievance is under the Social Service door." LPN #2's written statement dated 4/30/2011 indicated, "It was reported to me from (CNA #1) @ 8:20 A.M. that Resident F told her the CNA at night stated she was not going to take care of her because of the things she said. She was asked what she had said et (Resident F) states she only asked why she isn't getting a shower...." CNA #2's written statement dated 4/30/2011 indicated, "....(Resident F) asked (CNA #1) who was the stringy hair (sic) that works nights. We didn't say a name, but we know who she was talking about, and she stated that she said she wasn't going to take care of her, cause she knows what she said about her...." LPN #3's written statement dated 4/30/2011 lacked any indication of any problems during her shift. CNA #3's written statement dated 4/30/2011 lacked any indication of any			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	problems during her shift. CNA #3 was suspended on 4/30/2011 and terminated on 5/2/2011 for "inappropriate in her approach c (with) resident...." Resident F's clinical record was reviewed on 8/25/2011 at 4:11 P.M. Resident F's diagnoses included, but were not limited to, CVA (cerebral vascular accident), depression, osteoarthritis, senile dementia, and hypertension. Resident F's quarterly MDS (minimum data set) assessment BIMS (Brief Interview for Mental Status) dated 2/4/2011 indicated a total score of 11 indicating moderate cognitive impairment. 4. Review of an "Accident/Incident Report" dated 8/19/2011 at 2:05 P.M. indicated Resident E had reported to "staff that (CNA #4) was mistreating him and slammed him in his chair - states he is afraid (CNA #4) may do something to him." The SSD interviewed Resident E on 8/19/2011. The SSD has written "he heard that someone wasn't being nice to him. (Resident E) stated 'I don't want to get anyone in trouble'. SSD informed			

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	155064	A. BUILDING 00 B. WING	08/25/2011

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	(Resident E) that he is here to help him, and needs to know if someone is mistreating him. (Resident E) then stated 'well... today he slammed me in my chair.' When asked 'who?' (Resident E) stated '(CNA #4).' (Resident E) then stated 'I don't want to say nothing... I don't want him to be mad.' SSD reassured (Resident E) that he did the right thing in talking about it, and no one will be mad at him. SSD asked (Resident E) if anything else happened, and (Resident E) replied 'No, just he slammed me in my chair'. Resident E then stated 'I don't care if the girls help me get ready, I don't want him to'...." CNA #4 was suspended on 8/19/2011. The termination form indicated "Reported that (CNA #4) had 'slammed a resident in his w/c.' Investigation completed 8/22/2011 - (CNA #4) will be terminated because he probably handled res. inappropriately." Resident E's clinical record was reviewed on 8/25/2011 at 3:10 P.M. Resident E's diagnoses included, but were not limited to, paralysis, intracranial hemorrhage, urine retention, dementia, depression, and right sided hemiparesis. Resident E's quarterly MDS (minimum data set) assessment BIMS (Brief Interview for Mental Status) dated			

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	8/16/2011 indicated a total score of 12 indicating moderate cognitive impairment. During an interview with the DON on 8/25/2011 at 3:30 P.M., she indicated she thought CNA #4 had most likely slammed Resident E into his wheelchair and so he was terminated. 5. Review of a FAX/Incident report regarding Resident C dated 4/29/11 indicated "Resident spoke with MDS (minimum data set) coordinator asked residen (sic) how she was and she stated 'I hurt' continues to say that the CNA that works at noc (night) is rough with me. She just pulls and tugs on me like a dog. The CNA works at night...." The CNA was suspended pending an investigation. Review of the statement dated 4/29/2011 written by the MDS coordinator indicated "This writer spoke c (with) pt (patient) this am. I asked her how she was she stated 'I hurt.' ... say that the CNA that works @ noc is rough c me. 'She just pulls & tugs on me like a dog.' ... She said she doesn't want to complain or get anyone in trouble." The hand written statement by CNA #5 on 4/29/2011, indicated ".... stated she was in pain.... After nurse gave her medicine I			

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	procede (sic) to get (Resident C) ready. I helped (Resident C) wash up and noticed a small scab on her left leg I then called nurse back in to show her and she said it was already reported as she was walking out (Resident C) yelled hurry up its hot in here (sic). I then assist with putting resident's shirt on then pants. She then got upset again stating that her pants were to tight to get her others now. By this time (Resident C) was very agitated. I got (Resident C) a new pair of pants and assisted with putting them on." CNA #5's written report for the date of 4/29/2011 indicated Resident C was in a "bad mood -said she was in pain." The conclusion of the investigation dated 5/2/2011 indicated "IDT (interdisciplinary team) met this day and discussed all information submitted in the allegation of abuse with (Resident C). It is concluded the Aide was inappropriate in her approach to (Resident C). The aide will be terminated on this date May 2, 2011." Resident C's closed clinical record was reviewed on 8/25/2011 at 1:25 P.M. Resident C's diagnoses included but were not limited to, coronary artery disease, Right hip fracture with total hip replacement, peripheral neuropathy,			

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	pacemaker, and atrial fibrillation. She was admitted to the facility for therapy and was discharged home on 6/26/2011. Resident C's Admission MDS (minimum data set) assessment dated 3/15/2011 indicated a BIMS (Brief Interview for Mental Status) score of 15/15 indicating she was cognitively intact. Review of the "Resident Abuse Prevention" policy provided by the DON on 8/25/2011 at 4:30 P.M. indicated "It is the policy of this company that each facility will take all necessary action (sic) to protect residents from any form of abuse...." This federal tag relates to complaint IN00095480. 3.1-27(a)(1) 3.1-27(a)(3) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed ensure all allegations of abuse were reported to the ISDH immediately, regarding an allegation of staff to resident physical abuse, for 1 of 5	F0225	Correctie Action: Resident F has been assessed. She has not suffered no physical or psychological effects from the alleged event that occurred. All allegations of abuse are now	08/26/2011

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	residents with allegations of abuse in a sample of 6 (Resident F). Findings include: 1. A "Grievance/Complaint Report" dated 4/30/11 was reviewed. Resident F had filed a complaint against a CNA who works at night. The SSD had interviewed Resident F on 4/30/2011 with a written interview. Resident F had said "'I got the girl mad... she said she's not going to take care of me anymore because of something I said.' She then stated 'I'm 99 years old, I can't remember what I said. I tried to apologize, yet when she left she was so mad.' (Resident F) then stated 'I refused to take a shower. I used my walker today to walk to my bathroom.'" RN #1 had interviewed Resident F on 4/30/2011 with Resident F saying "The girl was going to give me a shower in my w/c (wheelchair). I got the girl mad - she said she wasn't going to take care of me anymore. She said I said something. I tried to apologize - she was so mad. She wanted to give me a shower, but I didn't want a shower...." CNA #3's written statement dated 4/30/2011 lacked any indication of any		immediately reported to a member of administration in the absence of the Administrator. The administrator or a member of administration shall immediately notify the Indiana State Department of Health in accordance with the reportable event gudelines.Identification: All allegations are being immediately reported to the administrator of in the absence of the administrator a member of administration. The facility has adopted a practice that upon receiving an allegation of abuse or suspected abuse the report will be faxed to the Indiana State Department of health in acoordance with the reporatble event guidelines and the confirmation receipt of the report is being retained and placed with the investigation file. System Change: A mandatory in service has been provided for staff related to facility abuse policy. In addition the facility will print out the confirmation to be retined with investigation file.Monitoring: Following any allegation of abuse the IDT team will meet and review the event. The team will validate that all components of facility abuse policy have been followed in accordance with the reportable event guidelines. All reportable events will be reviewed at our daily stand up meeting conducted Monday thru Friday. Any continuing issue/ or problems will be referred to our QAA committee for further recommendations and	

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	problems during her shift. CNA #3 was suspended on 4/30/2011 and terminated on 5/2/2011 for "inappropriate in her approach c (with) resident...." The facility had reported this allegation of abuse to the ISDH on 5/2/2011 at 11:30 A.M. During an interview with the DON on 8/25/2011 at 11:30 A.M., she indicated she did not know why this was not reported sooner. Review of the "Resident Abuse Prevention" policy provided by the DON on 8/25/2011 at 4:30 P.M. indicated "....2. The Administrator will take appropriate actions following the completion of the investigation and the preparation of a written report and statements. Such actions may include, but not be limited to: notification of state agency....5. The Administrator is responsible to ensure that all alleged violations and all substantiated incidents are reported to the applicable state agencies in accordance with regulations. The Administrator is responsible to ensure that all corrective actions have been taken depending on the results of the investigation...." This federal tag relates to complaint		or resolutions. The QAA committee may discontinue the monitoring once the facility is in compliance.ADDENDUM: AS PER POLICY OF THE FACILITY THE DON IS THE DESIGNATED INDIVIDUAL IN THE ABSENCE OF THE ADMINISTRATOR. IN THE EVENT THAT THIS INDIVIDUAL IS NOT AVAILABLE IT WILL BE RESPONSIBILITY OF THE SOCIAL SERVICE DIRECTOR TO ASSURE THAT THE ALLEGATIONS ARE REPORTED TO THE INDIANA STATE DEPARTMENT OF HEALTH ACCORDING TO THE REPORTING EVENT GUIDELINES. Any reportable events will be reviewed weekly for three weeks through our IDT process monthly for three months throurgh our monthly Clinical Compliance reviews, and then quartrerly for three quarters utilizing our QAA process. Any continuing issues/ or problems will be brought back to the QAA committee for further recommendations and /or resolution.	

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	IN00095480. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed follow their policy to ensure all allegations of abuse were reported to the ISDH immediately, regarding an allegation of staff to resident physical abuse, for 1 of 5 residents with allegations of abuse in a sample of 6 (Resident F). Findings include: 1. A "Grievance/Complaint Report" dated 4/30/11 was reviewed. Resident F had filed a complaint against a CNA who works at night. The SSD had interviewed Resident F on 4/30/2011 with a written interview. Resident F had said "'I got the girl mad... she said she's not going to take care of me anymore because of something I said.' She then stated 'I'm 99 years old, I can't remember what I said. I tried to apologize, yet when she left she was so mad.' (Resident F) then stated 'I refused to take a shower. I used my walker today to walk to my bathroom.'"	F0226	Corrective Action: The resident as identified as resident F no longer resides in the facility. In the event other allegations occur they will be reported immediatrely to the administrator or in the absence of the administrator they will be reported to a member of administration. They will initiate the investigation and shall be responsible for reporting the initial report to the Indidana State Departmen of Health. Identification: Any allegation of abuse will be immediatley be reported to administration who in turn will notify the Indiana State Department of Health in accordance with the reportable events guidelines. A confirmation of the receipt of this report will be printed and placed with the investigation file. Any employee who fails to follow the facility abuse policy will be subject to the facility's disciplinary action up to and including termination of employment.System change: A mandatory in-service was provided to facility staff on the facility abuse policy. The staff was advised that failure to follow the	08/26/2011

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	RN #1 had interviewed Resident F on 4/30/2011 with Resident F saying "The girl was going to give me a shower in my w/c (wheelchair). I got the girl mad - she said she wasn't going to take care of me anymore. She said I said something. I tried to apologize - she was so mad. She wanted to give me a shower, but I didn't want a shower...." CNA #3's written statement dated 4/30/2011 lacked any indication of any problems during her shift. CNA #3 was suspended on 4/30/2011 and terminated on 5/2/2011 for "inappropriate in her approach c (with) resident...." The facility had reported this allegation of abuse to the ISDH on 5/2/2011 at 11:30 A.M. During an interview with the DON on 8/25/2011 at 11:30 A.M., she indicated she did not know why this was not reported sooner. Review of the "Resident Abuse Prevention" policy provided by the DON on 8/25/2011 at 4:30 P.M. indicated "....2. The Administrator will take appropriate actions following the completion of the investigation and the preparation of a		facility abuse policy will result in disciplinary actions which may include termination of employment. In addition the facility has adopted the practice of printing out the confirmation of receipt of this report to the Indiana state Department of Health and placing it in the investigation file.Monitoring: Following any allegation of abuse the interdisciplinary team will review the event. The team will validate that all components of the abuse policy have been followed in accordance with the reportable events guidelines. All reportable events will be reviewed in the monthly clinical meeting and any continuing issues or problems will be referred to our QAA committee for further recommendations and or resoplutions.ADDENDUM: AS PER POLICY OF THE FACILITY THE DON IS THE DESIGNATED INDIVIDUAL IN THE ABSENCE OF THE ADMINISTRATOR. IN THE EVENT THAT THIS INDIVIDUAL IS NOT AVAILABLE IT WILL BE THE RESPONSIBILITY OF THE SOCIAL SERVICE DIRECTOR TO ASSURE THAT THE ALLEGATIONS ARE REOPORTED TO THE INDIANA STATE DEPARTMENT OF HEALTH ACCORDING THE REPORTING EVENT GUIDELINES. Any reporttable events will be reviewed weekly for three weeks through our IDT	

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	written report and statements. Such actions may include, but not be limited to: notification of state agency....5. The Administrator is responsible to ensure that all alleged violations and all substantiated incidents are reported to the applicable state agencies in accordance with regulations. The Administrator is responsible to ensure that all corrective actions have been taken depending on the results of the investigation...." This tag relates to complaint IN00095480. 3.1-28(a)		process , monthly for three months through our Clinical Compliance reviews, and quarterly for three quarters utilizing the QAA process. any continuing issues / and or problems will be brought to the QAA committee for further recommedations and / or resolution.	